FALLON COMMUNITY HEALTH PLAN, INC.

RIDER 6401

This is part of your
2004 Fallon Senior Plan™
Member Handbook/Evidence of Coverage

You are a member of Fallon Senior Plan™ through the Commonwealth of Massachusetts retiree group plan. Under this group plan you have certain benefits that are different from those shown in your 2004 Fallon Senior Plan™ *Member Handbook/Evidence of Coverage*. The information in this rider replaces any information in your *Member Handbook/Evidence of Coverage* that conflicts with it.

- **You have coverage for inpatient mental health care in an acute care hospital or psychiatric hospital for as many days as medically necessary.**
- **You have coverage for one hearing exam and one hearing aid every 24 months.**
- **You have coverage for participation in a coronary artery disease secondary prevention program.**
- **You have coverage for certain additional oral surgery services if you have a serious medical condition.**
- **You have coverage for certain voluntary family planning services**

The following changes apply to the benefits chart on pages 24 to 57 of your 2004 Fallon Senior Plan™ *Member Handbook/Evidence of Coverage*:

 (continued)

Benefits chart – your covered services	**What you must pay** when you get these covered services

INPATIENT SERVICES

Inpatient mental health care

Includes mental health care services that require a hospital stay. *Inpatient mental health care requires prior authorization (approval in advance) from the plan to be covered.* You are covered for an unlimited number of days of inpatient mental health care in an acute care hospital or psychiatric hospital. Note: Although your Fallon Senior Plan™ benefit is not subject to a limit, your Medicare benefit for inpatient care in a psychiatric hospital is limited to 190 days during your lifetime. If you should return to Original Medicare or change to another Medicare + Choice plan, any inpatient psychiatric hospital days you use while a member of Fallon Senior Plan™ are applied to your Medicare lifetime limit.	There is no copayment for inpatient mental health care. See Section 14 for an explanation of "benefit period."

Benefits chart – your covered services	**What you must pay** when you get these covered services

OUTPATIENT SERVICES

Outpatient substance abuse services (including partial hospitalization services)

Partial hospitalization services require prior authorization (approval in advance) from the plan to be covered.

"Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor or therapist's office and is an alternative to inpatient hospitalization.

You pay a $10 copayment for each Medicare-covered visit for outpatient substance abuse services.

There is no copayment for partial hospitalization services.

ADDITIONAL BENEFITS

Oral surgery services

Oral surgery services, with the exception of the removal or exposure of impacted teeth, require prior authorization (approval in advance) from the plan to be covered.

- Surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services

You pay a $10 copayment for each office visit for oral surgery services.

There is no copayment for oral surgery services in an ambulatory surgical center, day surgery or hospital outpatient facility when you have a serious medical condition.

(continued)

Oral surgery services, continued

that would be covered when provided by a doctor).

- Removal or exposure of impacted teeth, including hard and soft tissue impactions, or an evaluation for this procedure. (As explained in Section 2, you can get this service on your own, without a referral from your PCP as long as you get it from a plan provider.)
- Surgical treatments of cysts affecting the teeth or gums.
- Evaluation and surgery for the treatment of temporomandibular joint disorder when a medical condition is diagnosed.

In addition, the following oral surgery services are covered when you have a serious medical condition that makes it essential that you be admitted to a hospital as an inpatient, or to an ambulatory surgical center, day surgery or hospital outpatient facility in order for the services to be performed safely. A serious medical condition includes, but is not limited to,

There is no copayment for inpatient oral surgery services when you have a serious medical condition.

Benefits chart – your covered services	What you must pay when you get these covered services
Oral surgery services, continued	
hemophilia or heart disease. • Extraction of seven or more teeth • Gingivectomies (including osseous surgery) of two or more gum quadrants • Excision of radicular cysts involving the roots of three or more teeth • Removal of one or more impacted teeth	
Hearing services	
Diagnostic hearing exams require prior authorization (approval in advance) from the plan to be covered. • Diagnostic hearing exams • Hearing aid evaluation, limited to once every 24 months • Hearing aid, limited to one every 24 months	You pay a $10 copayment for each Medicare-covered diagnostic hearing exam. You pay a $10 copayment for each covered hearing aid evaluation. Hearing aid: - The plan pays 100% of the first $500 of the purchase price and 80% of the next $1,500 of the purchase price for your

(continued)

Benefits chart – your covered services	**What you must pay** when you get these covered services
Hearing services, continued	hearing aid (maximum benefit $1,700). - You pay 20% of the purchase price between $501 and $2,000 for your hearing aid, plus any additional costs.
Reconstructive surgery (including restorative surgery) *Reconstructive surgery (including restorative surgery) requires prior authorization (approval in advance) from the plan to be covered.* • Reconstructive surgery to improve or restore bodily function, correct functional physical impairment resulting from an accidental injury, disease, congenital anomaly or previous non-cosmetic surgical procedure • Restorative surgery to repair physical appearance damaged by accidental injury or disease • Reconstructive surgery for postmastectomy patients as follows: (1) reconstruction of the breast on which the mastectomy was performed,	You pay a $10 copayment for each office visit for reconstructive surgery. There is no copayment for covered services in an ambulatory surgical center, day surgery or hospital outpatient facility. There is no copayment for inpatient hospital services.

Benefits chart – your covered services	What you must pay when you get these covered services
Reconstructive surgery, continued	
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (3) treatment for any physical complications resulting from the mastectomy including lymphademas Note: Surgery for cosmetic reasons is not covered, whether intended to improve an individual's emotional outlook or to treat a mental health condition.	
Coronary artery disease secondary prevention program	
For members with know cardiovascular disease, the program shows you how to make healthy lifestyle changes. Contact Customer Service for more information.	You pay a $200 copayment for the program; upon completion you are eligible for a $100 reimbursement of the copayment amount.
Voluntary family planning services	
• Birth control information and counseling • Reproductive health education and disease prevention	You pay a $10 copayment for each office visit for voluntary family planning services.

(continued)

Benefits chart – your covered services	**What you must pay** when you get these covered services

Voluntary family planning services, continued

- Genetic counseling
- Contraceptive devices
- Pregnancy termination
- RU-486

On **page 61,** under **"Medical care and services that are not covered (list of exclusions and limitations),"** delete exclusion number 24 as not applicable.

On **page 71-72,** under **"Prescription drug benefit exclusions (drugs that are not covered),"** change the first bulleted item to: "Drugs or devices that you can buy without a prescription," and delete the fifth bulleted item: "Devices for birth control" from the list of drugs that are not covered. You have coverage for contraceptive devices; see **"Voluntary family planning services"** above.